EC-1

rev Oct 2009

Hawaii Employer-Union Health Benefits Trust Fund
ENROLLMENT FORM FOR ACTIVE EMPLOYEES

PLEASE SUBMIT THIS FORM EC-1 TO YOUR PERSONNEL OFFICE

SECTION A - EMPLOYEE DATA

Please complete all applicable fields below. Social Security Numbers are required to process new employee and dependent enrollments.

Gender: ☐ Male ☐ Female
Birth Date: (MM/DD/YY)
/ /

☐ New Hire
Date of Hire / /
☐ Open Enrollment

☐ Mid-Year Event Changes
Event
Event Date / /

Employee's Last Name, First Name, Middle Initial
(enter your full legal name as recorded on your Social Security card)

Employee's Social Security Number or EUTF ID Number

If you are a new employee, you are required to provide your social security number. Otherwise, enter your EUTF ID number above.

Residence Address (☐ Check this box it your address has changed)

City | State | Zip Code

Mailing Address (if different from above)

City | State | Zip code

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide their SSN below.

Social Security Number:

Marital Status	Marriage Date (MM/DD/YY)	Domestic Partnership (DP) Status	DP Date (MM/DD/YY)	Phone Number – Work / Home
☐ Married ☐ Single	/ /	☐ IRS Qualified ☐ Not Qualified	/ /	(W) (H)

SECTION B – COVERAGE SELECTIONS

Make your selection by checking the box for the appropriate benefit plans below.
Select Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan section.

Plan	Type	Carrier Selection	Self	2-Party	Family	Cancel/ Waive
Medical Plan Select one plan from this list. Except for the HDHP plan as noted, the RSN chiropractic plan is included with the medical plan.	PPO	90/10 PPO-Health Management Associates **(HMA)** w/ RSN ChiroPlan	☐	☐	☐	
		80/20 PPO-Hawaii Medical Service Association **(HMSA)** w/ RSN ChiroPlan	☐	☐	☐	
	HMO	HMO-Hawaii Medical Service Association **(HMSA)** and Drug w/ RSN ChiroPlan	☐	☐	☐	
		HMO-Kaiser Basic <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	
		HMO-Kaiser Comprehensive <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	☐
	HDHP	HDHP-High Deductible Health Plan **(HMSA)** <Medical and Drug>	☐	☐	☐	
	Supplemental	Supplemental-Hawaii Medical Service Association **(HMSA)**, InformedRx Supplemental Drug <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	
		Supplemental-Royal State National Insurance Company **(RSN)**, RSN Drug <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	
Prescription Drug Plan If you want drug coverage with a PPO plan, select this option.		InformedRx Prescription Drug (not a valid selection w/ the HMO, HDHP, or supplemental medical plans)	☐	☐	☐	☐
Dental Plan		Hawaii Dental Service (HDS) - Dental	☐	☐	☐	☐
Vision Plan		Vision Service Plan (VSP) - Vision	☐	☐	☐	☐
Life Insurance Plan		Standard Insurance Company - Life Insurance	☐			☐

For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll ☐ Do NOT Enroll ☐ Change Amount ☐ Cancel PCP

For COUNTY Employees ONLY: Premium Conversion Plan - Please contact your DPO for more information on available options.

SECTION C – DEPENDENT INFORMATION AND COVERAGE SELECTIONS

List all eligible dependents you wish to cover and check the plan selections desired. Relationship Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship or Foster child, and DC=Disabled Child if your child is age 19 or over and is also disabled. Please see specific instructions in Section C for additional details.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YY)	Social Security Number or EUTF ID Number	Relationship	Gender	Medical	Drug	Dental	Vision
☐	☐		/ /			☐M ☐F	☐	☐	☐	☐
☐	☐		/ /			☐M ☐F	☐	☐	☐	☐
☐	☐		/ /			☐M ☐F	☐	☐	☐	☐
☐	☐		/ /			☐M ☐F	☐	☐	☐	☐
☐	☐		/ /			☐M ☐F	☐	☐	☐	☐
☐	☐		/ /			☐M ☐F	☐	☐	☐	☐
☐	☐		/ /			☐M ☐F	☐	☐	☐	☐

Dependent Certification and Student Certification– See Section C.6 and C.7 for more information. Detailed eligibility information is available at eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.

I certify that all of my dependent children meet eligibility requirements for enrollment in the EUTF plans. _________ **(initials)**

I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _________ **(initials)**

Domestic Partner Certification – See Section C.8 and C.9. for specific instructions. Detailed eligibility information is available at eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes and Domestic Partner Enrollment Instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _________ **(initials)**

SECTION D - OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family, etc).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
			/ /	Self ☐	2-Party ☐	Family ☐
			/ /	Self ☐	2-Party ☐	Family ☐

SECTION E - EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on the enrollment form are also eligible. I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: ____ Date Signed: __________________

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1 Received in Employing Office / /		DPO Phone Number	DPO Fax Number
DPO (or employer designee's) Printed Name DPO (or employer designee's) Signature:			Date of DPO (or employer designee's) Signature / /

Remarks: